

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-046205

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **39** Primary Registration District No. _____ Registrar's No. **104**

FILED DEC 19 1962

1. PLACE OF DEATH a. COUNTY CASS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY Tarrant	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt Pleasant Township		c. CITY OR TOWN Fort Worth	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 328th USAF Hospital Richards-Gebaur AFB, Mo		d. STREET ADDRESS (If outside, give location) 2520 Moresby	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Marion Middle Eugene Last Frost			4. DATE OF DEATH Month December Day 10 Year 1962		
5. SEX Male	6. COLOR OR RACE Cau	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-13-33	9. AGE (last birthday) 29	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Supt		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and state or country) Downsville, La	
12. CITIZEN OF WHAT COUNTRY USA					

13a. FATHER'S NAME John H. Frost		13b. MOTHER'S MAIDEN NAME Roxie Woolsey		14. NAME OF HUSBAND OR WIFE Mary Lou Frost	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Mary Lou Frost Address 2520 Moresby Fort Worth, Texas	

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Laceration		INTERVAL BETWEEN ONSET AND DEATH 3 Hours
DUE TO (b) Multiple Skull Fractures		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Patient fell from the roof of a hangar being built at Richards-Gebaur AFB, Mo., to the concrete flight line, a distance of approximately 35 feet.
20c. TIME OF INJURY Hour 10:30 AM a.m. Month, Day, Year Dec 10, 62		
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Richards-Gebaur AFB, Mo.	20f. CITY, TOWN, OR LOCATION See Item 20b.

21. I attended the deceased from 10 December 1962 to 10 Dec 1962 and last saw ^{her} him alive on 10 December 1962	
Time of death occurred at 1:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>M.L. Cheatham</i> M.L. CHEATHAM, CAPT, USAF, MC	22b. ADDRESS 328th USAF Hospital Richards-Gebaur AFB, Missouri
22c. DATE SIGNED 10 Dec 1962	

23a. BURIAL, CREMATION, REMOVAL (Specify) Personal	23b. DATE 12-11-62	23c. NAME OF CEMETERY OR CREMATORY Fort Worth Texas
24. FUNERAL DIRECTOR <i>E.K. George Jones Inc</i> E.K. George Jones Inc	25. DATE RECD. BY LOCAL REG. 12-11 62	26. REGISTRAR'S SIGNATURE <i>Ray J. Seibel</i> Ray J. Seibel

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

(INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

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Rev. 4/59

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FEB 1 1963

FEB 5 1963

MAR 25 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Jimmy S. Hushon

Licensed Embalmer No. 4092

P. O. Address Belton, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.